

**CHANGE LICENSURE
APPLICATION PACKET
FOR
ADULT CARE HOME
(7 OR MORE BEDS)**

Return the entire packet to

**Division of Facility Services
Adult Care Licensure Section
2720 Mail Service Center
Raleigh NC 27699-2720
Attn: License Materials Enclosed**

**STEPS FOR A CHANGE OF OWNERSHIP
FOR ADULT CARE HOMES WITH 7 OR MORE BEDS**

Please read and follow these steps to complete a change of ownership successfully

1. The applicant or prospective licensee must contact the Certificate of Need with the Division of Facility Services:
 - i. To obtain a letter of exemption from review from the Certificate of Need (CON) (*when licensee is changing but ownership of building is not*); OR
 - ii. Prior to the obligation to purchase the building (*when the applicant or prospective licensee plans to purchase the building*).
2. The current licensee informs the Adult Care Licensure Section (ACLS), Raleigh office, the county department of social services and the residents or their responsible persons in writing of the proposed change of business ownership and the date of the change. This contact should be made at least 30 days in advance of the proposed change.
3. The Construction Section of the Division of Facility Services must approve any proposed structural changes of building before a license can be approved. (See page 4 for review form)
4. Unpaid fines for penalties imposed will result in denial of licensure. License applications will not be processed if there are any outstanding/unpaid fines for penalties.
5. The applicant/prospective licensee compiles the following information and submits it to the Adult Care Licensure Section, Raleigh office.
 - a. Adult Care Home Licensure Change Application to facilitate compliance history check
 - b. Licensure Fee form found at <http://facility-services.state.nc.us/forms.htm> and submit payment for the non-refundable licensure fee of the prorated fee calculated. "Non-refundable Licensure Fee" (Prorated fee in the form of check, money order or certified check and must be payable to the "NC Division of Facility Services.")
 - c. Administrator Certificate/License
 - d. Approved fire and building safety inspection reports
 - e. Approved sanitation inspection report
 - f. Upon completion of any construction or renovation, -a certificate of occupancy or certificate of compliance from local building officials
 - g. Letter from previous owner relinquishing ownership (this letter must specify the date of the change in ownership)
 - h. Copy of CON letter (Licensure applications cannot be processed without approval or exemption by CON)
 - i. **Note: Any information not included in the packet will render the application incomplete and it will not be processed.**

6. Within 14 working days of receipt of the above information or packet, the Adult Care Licensure Section will review and contact the prospective licensee for additional information if needed. If all documentation is complete, the Adult Care Licensure Section will issue a new license to the applicant.
7. Staff with the Division of Facility Services and county department of social services will conduct a survey, after license is issued to the facility.
8. Licenses must be renewed annually using the Annual Renewal License Application and submitting a non-refundable annual licensure renewal fee of \$350.00 plus a per-bed fee of \$12.50.

Mailing address of Raleigh Adult Care Licensure Section:

Regular Mail:

Division of Facility Services
Adult Care Licensure Section
2720 Mail Service Center
Raleigh NC 27699-2720
Attn: License Materials Enclosed

Express/Overnight Mail:

Division of Facility Services
Adult Care Licensure Section
701 Barbour Drive
Raleigh, North Carolina 27603
Attn: License Materials Enclosed

Adult Care Licensure Section (Raleigh Office) : 919-855-3765

**Construction Licensure Plan Review
Information For
Adult Care Licensure Section**

Please complete this form only if structural changes to the building have been made

**Please do not send Construction Section Fee payment for Adult Care Home projects.
The Construction Section will bill you.**

PLEASE PRINT

Current Name of Facility_____

New Name of Facility (if applicable)_____

Site Address_____

Site City, State, and Zip_____

County_____

Contact Person_____ **Contact Phone Number()**_____

Address_____

Site City, State, and Zip _____

Requested Information:

Applicable Licensure Rules: _____ Family Care Rules or _____ Adult Care Rules

Number of beds requested_____

Status of Residents:

 _____ All Ambulatory

 _____ Non-Ambulatory, 1-3

 _____ Non-Ambulatory, More than 3

Review For : _____ Initial Licensure _____ Capacity Increase _____ Remodeling _____ Other

Return this form: Adult Care Licensure Section
 2720 Mail Service Center
 Raleigh, NC 27699-2720
 ATTN: Karen Jones

Office Use Only

Date Received_____

FID_____ LICENSE NUMBER_____

Team Supervisor/Branch Manager(C A R L)_____

Comments_____

Instructions for Completing a Change Licensure Application

Overview

1. These instructions are provided to assist you in completing a change or renewal application.
2. Failure to provide all requested information will result in delaying the processing of the application. If the information does not pertain to your facility mark N/A in the area.
3. Change requests must be submitted at least 60 days prior to the anticipated change. See Change of Ownership Fees chart at end of instructions. Construction related fees will be invoiced to you at a later date (change of capacity, change of location).

Type of Licensure Application

1. **Facility Type#:** Select Adult Care Home (7 or more beds) or Family Care Home (2-6 Bed).
2. Check the appropriate box/boxes for the action you are requesting. If the action is not listed, fill in the blank beside "Other".
 - **Change of Location**
 - ☐ Within the same county on license: Complete this application and submit zoning approval, photos, floor plan and Physical Plant sheet (page 4).
 - ☐ To a different county than on license: Complete an Initial License Application.
 - **Change of Capacity:** if change of capacity is an increase, submit photos, floor plan.
 - **Change of Facility Name:** Complete this application.
 - **Change of Licensee/Ownership:** Complete this application. A fee is assessed for a change of ownership, see fee chart for payment that must accompany application.
 - **Requested Effective Date of Change:** Enter date when you are requesting that the change be effective. This maybe related to other changes that are occurring with your business.

Current Information

1. Current Facility Name: Enter name printed on your most current license.
2. Current Facility Site Address: This address is the physical site location as printed on most current license.
3. Current Legal Identity of Ownership/Licensee: This is the name printed on your license as the licensee/owner. Please complete address & phone information.
 - *Note fee charge for a change of ownership.

Requested Changes

In pages 9-14, please complete **only** those changes you are requesting.

1. Facility Name: Enter the name of the facility that will be printed on your license.
2. Facility Site Address: Enter the new physical location of your facility.
3. Name of Contact Person: This person can answer daily process and licensure questions about the facility.
4. Facility Correspondence Mailing Address: This address will be where you will receive all mail for the facility. Indicate the name to address correspondence.
5. Identify the legal entity of the licensee Legal Identity of Ownership/Licensee: This is the name that will be printed on the license as licensee/owner.
6. Check if you are registered with the state as profit or non-profit
7. Type of entity under which the business is operated. All entities should be registered with the state except proprietorship and private partnership.
8. Identify the administrator for this facility.
9. Management Company: Enter this information if a company other than the licensee will manage the facility.
10. Supply information for Executive Officer if applicable.
11. If you lease the building, complete the data on the person from whom you lease/rent.
12. Owners, Partners, Affiliates, Shareholders
13. If this is a proprietorship (private) business with no shareholders or a non-profit entity, Signature and title and date needed in 1st box.
14. The application must be signed to be processed.

**PLEASE READ CAREFULLY
INITIAL AND CHANGE OF OWNERSHIP
LICENSURE FEE INFORMATION**

Effective March 1, 2006, license fees that accompany an initial license application or a license application for a change of ownership will be pro-rated based on the month the application is mailed and postmarked during the year.

The following information is provided to assist you in determining the correct licensure fee for your Adult Care Home. This information does not apply to annual licensure renewals.

Family Care Homes (six beds or less) have an annual licensure fee of \$250.

Adult Care Homes (seven beds or greater) have an annual licensure fee of a base rate of \$350 plus an additional cost of \$12.50 per licensed bed.

In order to determine the amount of the license fee that must accompany the application, please use the following formula:

Multiply the annual license fee amount by the factor below, which corresponds to the month the application will be mailed and postmarked.

MONTH	FACTOR
January	1.0
February	0.92
March	0.83
April	0.75
May	0.67
June	0.58
July	0.5
August	0.42
September	0.33
October	0.25
November	0.17
December	0.08

For Adult Care Homes (seven beds or greater), the annual licensure fee is a base fee of \$350.00 plus \$12.50 for each licensed bed. Please apply the correct factor to this total based on the month you mail the licensure application.

$\$350 + [\$12.50 \times (\text{the number of beds to be licensed})] = \text{annual licensure fee}$

Licensure fee x month's factor = your licensure fee

EXAMPLE $\$350 + (\$12.50 \times 12 \text{ beds}) = \text{annual licensure fee}$

$\$350 + \$150 = \$500 \text{ annual licensure fee}$

$\$500 \times 0.58 \text{ (June's factor)} = \290

Your licensure fee for mailing application in June

The annual license fee for the facility is \$500 and the application will be postmarked on June 21st, a check for \$290 must accompany the license application.

*******For Family Care Homes (six beds or less),** the annual licensure fee is a flat base fee of \$250.00. Please apply the correct factor based on the month you mail the licensure application.

(\$250 x month's factor = your licensure fee)

EXAMPLE \$250 x 0.58 (June's factor) = \$145

Your licensure fee for mailing application in June

The annual license fee for the facility is \$250 and the application was postmarked on June 21, a check for \$145 must accompany the license application.

*******FAMILY CARE HOMES DO NOT SEND MONEY WITH YOUR APPLICATION. YOU WILL BE NOTIFIED OF THE AMOUNT FOR YOUR LICENSE.**

PLEASE NOTE: All license fees are nonrefundable regardless of when a license is finally issued.



N.C. Department of Health and Human Services

Division of Facility Services

Adult Care Licensure Section

2720 Mail Service Center ■ Raleigh, North Carolina 27699-2720

CHANGE LICENSURE APPLICATION FOR ADULT CARE FACILITIES

TYPE OF LICENSURE APPLICATION: Adult Care Home ☐
(7 or more beds)

Family Care Home ☐
(2-6 beds)

CURRENT FACILITY LICENSE Number- _____ - _____ - _____

☐ Change of Facility Name ☐ Change of Capacity ☐ Other (specify): _____
☐ Change of Licensee/Ownership ☐ Change of Location

Requested Effective Date of Change: _____

Note: Change in Ownership requires a license fee. Change of Location & Change of Capacity requires a Construction review and fee.

CURRENT INFORMATION (Prior to Change)

1. CURRENT FACILITY NAME: _____

2. CURRENT FACILITY SITE ADDRESS: **(NO P.O. BOXES)**

Street: _____

City _____ Zip Code _____ County _____

Facility Telephone Number (_____) _____ Fax Number (_____) _____

3. CURRENT LEGAL IDENTITY OF OWNERSHIP/LICENSEE:

Name of Owner: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Business Phone # of Applicant/Licensee: (_____) _____ Fax (_____) _____



North Carolina Department of Health and Human Services
Division of Facility Services
Adult Care Licensure Section
2708 Mail Service Center
Raleigh, NC 27699-2708

For Office Use Only

License# _____

FID _____

Reviewed _____ Date _____

Compliance Check Completed:

Date _____ By _____

Data Entry _____

CHANGE LICENSE APPLICATION FOR ADULT CARE/FAMILY CARE HOMES 2007

PLEASE READ CAREFULLY

- A license fee must accompany this application.
- Complete All Blanks, if not applicable mark N/A

For the purpose of this application the follow definitions apply:

The following definitions shall apply throughout this application:

- (1) "Person" means an individual; a trust or estate; a partnership; a corporation; or any grouping of individuals, each of whom owns five percent or more of a partnership or corporation, who collectively own a majority interest of either a partnership or a corporation.
- (2) "Owner" means any person who has or had legal or equitable title to or a majority interest in an adult care home.
- (3) "Affiliate" means any person that directly or indirectly controls or did control an adult care home or any person who is controlled by a person who controls or did control an adult care home. In addition, two or more adult care homes who are under common control are affiliates.
- (4) "Principal" means any person who is or was the owner or operator of an adult care home, an executive officer of a corporation that does or did own or operate an adult care home, a general partner of a partnership that does or did own or operate an adult care home, or a sole proprietorship that does or did own or operate an adult care home.
- (5) "Indirect control" means any situation where one person is in a position to act through another person over whom the first person has control due to the legal or economic relationship between the two.

REQUESTED CHANGES

FOR THIS OF THE APPLICATION, PAGES 10-14, PLEASE COMPLETE **ONLY** THOSE CHANGES REQUESTED.
For Change of Ownership, complete the entire application

Part A Facility Information

The name on this line is the name of your facility, as it is/will be printed on your license. If it is incorrectly spelled or you have changed the name of the facility, mark through and print in the correct name.

Facility Name:

(Exact name on your current license, name which the facility is advertised or presented to the public.):

Facility Site Address:

(physical location of facility)

County:

Facility Telephone:

Facility Fax:

Correspondence Mailing Address: (where you want to receive mail including the license from DFS):
Addressee:

Part B Operation Disclosure

1. **Certified or Qualified Administrator:** You must include the administrator's certificate number.

Name: _____

Address: _____ City _____

State _____ Zip _____ County _____ Telephone#: ____ (____) _____

Fax (____) _____

Administrator Certificate No. (if 7 beds or more) _____

Percentage Interest in this Facility: _____

2.MANAGEMENT COMPANY: If facility is managed by a company *other than the licensee*, provide the following information about the Management Company:

Name _____

Street/Box: _____

City _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Percentage of Ownership Interest in this Facility: _____

3. LEGAL IDENTITY OF LICENSEE

The preprinted name, address and phone number(s) is the data we currently hold for the facility/business owner. This is the name printed as "licensee" on the license. If this name appears incorrectly, please mark through in and print the name, as it should appear on the license. If any information is missing, please complete.

Licensee on current License

Street/Box: _____
City _____ State: _____ Zip: _____
Business Phone: _____ Fax: _____

Federal Tax ID number of Owner/Licensee: _____

Percentage of Ownership Interest in this Facility: _____

Legal entity is: _____ For Profit _____ Not For Profit

Legal entity is: _____ Proprietorship _____ Partnership _____ Limited Liability Company
_____ Corporation _____ Government Unit _____ Limited Liability Partnership

4. If the "licensee" is a corporation or partnership list the name of the Executive Officer or General Partner.

Executive Officer: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Business Phone #: () _____ Fax () _____

Percentage of Ownership Interest in this Facility: _____

5. **Building Owner:** If the above entity (partnership, corporation, etc.) **does not** own the building from which services are offered, provide the following information:

Name: _____

Street/Box: _____

City _____ State: _____ Zip: _____

Business Phone: () _____ Fax: () _____

Percentage of Ownership Interest in this Facility: _____

Part C Ownership Disclosure

1. OWNERS, PRINCIPLES, AFFILIATES, SHAREHOLDERS

Complete the information below on **all** individuals or entities who are owners, principles, affiliates or shareholders holding an interest of **5% or more** of the applicant entity. Attach additional pages if necessary.

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone # of Shareholder: () _____ Fax () _____
Percentage interest in this facility: _____ Title: _____
List the names of other Family Care/Adult Care homes in which you are the owner or affiliate _____

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone # of Shareholder: () _____ Fax () _____
Percentage interest in this facility: _____ Title: _____
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate _____

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone # of Shareholder: () _____ Fax () _____
Percentage interest in this facility: _____ Title: _____
List the names of other Family Care/Adult Care homes in which you are the owner or affiliate _____

I attest that this is a true account of all owners, principles, partners, and affiliates of shareholders who hold an interest of 5% or more of the entity applying for or renewing this license:

Signature

Title

Date

Print Name

Phone Number

2. EXTENSIONS IN OWNERSHIP

North Carolina General Statute also requires information about “affiliates” of the applicant entity.

- (a) Is the applicant entity controlled by any other organization that operates licensed adult care facility? Yes _____ No _____
- (b) Does the applicant entity control any other organizations that control any other licensed adult care facilities? Yes _____ No _____
- (c) Does the applicant entity control other adult care homes? Yes _____ No _____
- (d) If the answer to (a), (b) or (c) above is “Yes” list the name of the other organization(s) and provide the requested information on the individuals who control 5% or more of that organization. Attach additional pages if necessary.

Person/Organization Name: _____

Facility Name: _____ Federal Tax ID Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Organization Phone #: (_____) _____ Fax (_____) _____

Percentage of ownership Interest _____

List the names of other Family Care/Adult Care homes in which you are the owner or affiliate _____

Person/Organization Name _____

Facility Name: _____ Federal Tax ID Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Organization Phone #: (_____) _____ Fax (_____) _____

Percentage of ownership Interest _____

List the names of other Family Care/Adult Care homes in which you are the owner or affiliate _____

Person/Organization Name: _____

Facility Name: _____ Federal Tax ID Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Organization Phone #: (_____) _____ Fax (_____) _____

Percentage of ownership Interest _____

List the names of other Family Care/Adult Care homes in which you are the owner or affiliate _____

The following information will be used for internal compliance history checks as required by G.S. 131D-2b(1). We ask that you voluntarily provide your social security number with the understanding that it will be used only as an identification number for internal record keeping and data processing. Incomplete data will delay the renewal application being processed.

Category	Name	SSN	Contact Number	Percentage of interest as reported on pages 2-5
Administrator				
Licensee				
Licensee				
Building Owner				
Executive Officer				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				

Please use additional paper and attach if needed.

Reminder: failure to complete this information will delay the renewal process.

CAPACITY AND SPECIAL CARE UNITS

- ☐ Current total monthly private pay charge (average base plus add-ons if more than one price) for:
- ☐ Monthly Private Room (1bed/room) \$ _____
- ☐ Monthly Semi-Private (2 beds/room) \$ _____
- ☐ Monthly 3 or more beds/room \$ _____
- ☐ Licensed Capacity (as it appears on License) _____

Is your facility advertised, marketed, or promoted as providing a special care unit for residents with special needs such as Alzheimer's Disease or related disorders, mental health disabilities, or developmental disabilities? YES___ NO___

If "YES," prepare a disclosure statement according to the attached "Format for Special Care Unit Disclosure Statement" and submit it with this application unless such a statement has already been submitted. If your disclosure statement has been revised, please submit the revised statement, which must also be provided to the special care unit residents or their authorized representative.

Check any that apply:

Alzheimer's Special Care Unit in facility (Rules 13F .1300 apply) # of beds _____

Mental Health Disability Special Care Unit (Rules 13F .1400 apply) # of beds _____

Check if apply:

This Adult Care Home serves Only elderly persons.

Persons age 55 or older or who have a primary diagnosis of Alzheimer's disease or other form dementia that require assistance with activities of daily living.

Authenticating Signature: The undersigned submits this application for licensure for the year 2007 in accordance with Article 1 Chapter 131 D of the General Statutes of North Carolina and to the rules adopted there under by the North Carolina Medical Care Commission (10A NCAC13F) and certifies the accuracy of this information.

Signature: _____ Date: _____

Print Name _____ Phone Number _____

Please be advised, the license fee must accompany the completed application and be submitted to the Adult Care Licensure Section, Division of Facility Services, prior to the issuance of an Adult Care license.